MID-ATLANTIC ETHICS COMMITTEE NEWSLETTER

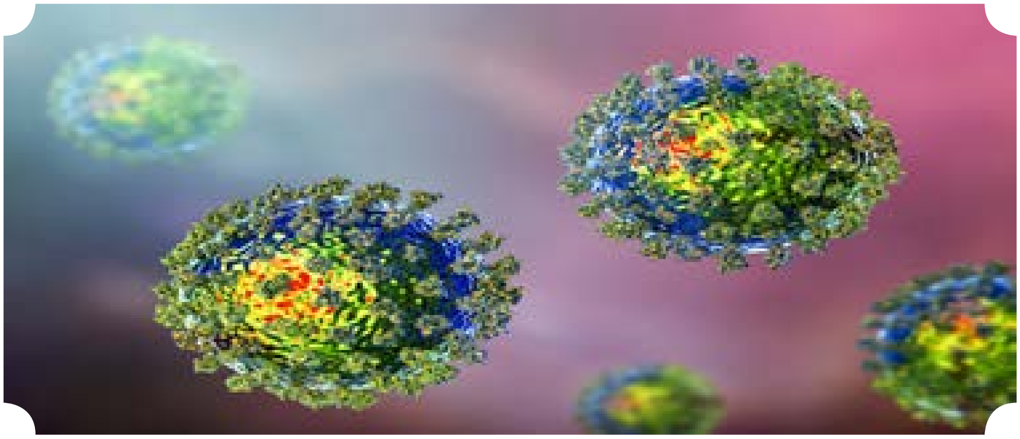
A Newsletter for Ethics Committee Members in Maryland, The District of Columbia and Virginia
Published by the Law & Health Care Program, University of Maryland Francis King Carey
School of Law and the Maryland Health Care Ethics Committee Network
Fall 2020

Inside this issue . . .

The *Mid-Atlantic Ethics Committee Newsletter* is a publication of the Maryland Health Care Ethics Committee Network, an initiative of the University of Maryland Francis King Carey School of Law's Law & Health Care Program. The Newsletter combines educational articles with timely information about bioethics activities. Each issue includes a feature article, a Calendar of upcoming events, and a case presentation and commentary by local experts in bioethics, law, medicine, nursing, or related disciplines.

Diane E. Hoffmann, JD, MS - Editor

The COVID-19 Pandemic in Maryland Through the Lens of the Maryland Healthcare Ethics Committee Network



We had an unprecedented spring with the arrival of the coronavirus pandemic, watching as it swept across both the globe and through our own communities and institutions throughout the United States. In Maryland, both the state and local governments and healthcare institutions have been engaged in mitigating the effects of the pandemic as they occur as well as preparing the necessary supporting documents, policies, and frameworks needed to guide the state through a potential surge (Gwon 2020). In this article, we discuss the efforts that were made in Maryland to prepare for the pandemic, in particular to prepare for the possibility of allocating scarce medical resources and what the future may bring, through the lens of Maryland Healthcare Ethics Committee Network's COVID-19 Working Group.

<u>Where We've Been</u>

Preparing for allocating scarce medical resources

Like several other states, Maryland began planning for a potential pandemic and the possible need to ration scare medical resources a number of years ago. From 2012-2014 the Berman Institute of Bioethics at Johns Hopkins University and the Johns Hopkins Hospital conducted a "deliberative democracy process" to engage Maryland residents about the values and principles that ought to guide a fair and ethical allocation of scarce medical resources during a pandemic or health catastrophe. These principles included considerations of distributive justice such as a "first come, first served" approach, a lottery based on equal opportunity; more utilitarian principles such as

**The Mid-Atlantic Ethics Committee Newsletter
is published three times per year by the Maryland Health Care Ethics Committee Network
Law & Health Care Program
University of Maryland
Francis King Carey School of Law**

**500 West Baltimore Street
Baltimore, MD 21201
410-706-7191**

Diane E. Hoffmann, JD, MS, Editor
Anita J. Tarzian, PhD, RN,
Co-Editor

Christen Paradissis, RN, MBE,
Co-Editor

**Comments to:
MHECN@law.umaryland.edu**

prognosis for short-term or long-term survival; or the fair innings theory, wherein those who have lived through the fewest stages of life receive priority.

The goal of this deliberative democracy framework was to reflect Maryland residents' views and promote public trust by creating a transparent, public dialogue. The the delibertive democracy process provided the foundation for the 2017 "Allocation of Scarce Resources Framework." Based on a series of focus groups, Framework authors took a utilitarian approach and agreed that the state's priority in allocating scares medical resources, such as ventilators during a pandemic, should be to prioritize the number of lives saved by looking at short-term and longer-term (1 year) survival. (Daugherty-Biddison et al. 2017). The Framework authors used life cycle (or fair innings) theory as a tiebreaker. The 2017 Allocation of Scarce Resources (ASR) framework also described in detail a scoring system, as well as procedures, for putting a triage system in place in the event of a public health crisis.

In March of this year the press reported news of coronavirus outbreaks decimating China, Italy, and New York, with hospitals overwhelmed and filled to capacity by a surge of patients. Also reported was the reality of rationing scarce medical resources including ventilators, ICU beds, medications and PPE (Cohn 2020, Hoffmann 2020). In response, in mid-March MHECN staff formed the COVID-19 Working Group, with representatives from member hospitals. The group began meeting twice weekly via Zoom to strategize and prepare hospitals in the state for the coming surge and the possible implementation of a rationing plan.

At these Working Group meetings, the 2017 ASR Framework was discussed, and group members shared how their institutions were developing triage teams and the procedural infrastructure to implement such a rationing plan. The Working Group also reached out to local media in order to educate the public about the existing 2017 ASR Framework and urged Maryland's governor to have a transparent process in adopting such a plan. MHECN leadership also reached out to disability rights groups to enlist their feedback and collaboration in the implementation of such a plan to try to avoid pitfalls of discrimination that brought other state plans under fire for violating civil rights laws.

Member institutions also asked that the Working Group clarify the nature of immunity provided by Maryland's Health Care Decisions Act (HCDA) and Maryland's Catastrophic Health Emergency Act (CHEA). The working group first made clear that clinical decisions to withhold or withdraw medically ineffective treatment under the HCDA differs from triage decisions, and second, noted that physicians who complied with a rationing plan, should the governor endorse and choose to implement one, would be given immunity from liability under the CHEA.

The meetings of the Working Group also provided an opportunity for members to share how their hospitals were faring with the surge. Those in Montgomery and Prince George's County, where the impacts of the virus were most keenly felt, offered that their facilities had come very close to needing to implement a triage plan for ventilators. Members of the Working Group also shared accounts of moral distress impacting frontline staff, particularly around new challenges in facilitating communication between patients and their loved ones, and the impacts of no visitor policies.

These biweekly meetings ran from mid-March until the end of April at which point, the Working Group transitioned to meeting once a week, and is now meeting every other week. While the impacts of the pandemic never got to the point that Maryland hospitals needed to ration ventilators, the Working Group was very concerned that the state never endorsed a rationing plan. This is at odds with the large majority of states across the country, which have a rationing plan that is accessible to the public. Maryland's lack of an official state plan led to considerable stress and confusion for several of our member hospitals who did not know if there was a state plan, if they needed to develop their own plan, or whether they would be protected from liability if they acted in accordance with the 2017 framework. The lack of a state plan also led to concern about the potential for inconsistencies in allocation and rationing between hospitals across the State.

As the Working group was having its regular discussions, a group of physicians (one from each of the largest health systems in the state: Johns Hopkins, University of Maryland, Medstar, LifeBridge, and Luminis, was working in parallel to refine the 2017 ASR Framework as well as to develop triage guidance for allocating other scarce resources such as dialysis machines, ECMO machines, and medications like remdesivir for their health care systems. MHECN has been working with the "5 Hospital Group" to make the plan available to all hospitals in the state, and to also make it available to the public for their engagement and review.

Looking Forward

As the year winds to a close several challenges present themselves, including the upcoming flu season and the difficult decision of whether, or in what capacity, to reopen or keep open state public schools and universities. Other concerns include, first and foremost, the potential for another surge, as well as the production, allocation, and distribution of a vaccine for coronavirus and an assessment of the state's current infrastructure to aid in that process. Longer-term concerns include the needs of frontline staff and institutional support as different institutions (including long-term care facilities) and their staff face variable degrees of stress, impacting personal and institutional health and wellbeing, and in turn their capacity to provide care to patients.

Christen Paradissis, RN, MBE
University of Utah
MHECN Program Coordinator

References

Cohn, M. (2020, March 28). Who gets a ventilator when there's a crush of coronavirus patients? Maryland is coming up with a plan. baltimoresun.com. https://www.baltimoresun.com/coronavirus/bs-hs-ventilator-surge-plan-20200327-dn-guwrff7vcrfj3sg45negc3na-story.html.

Daugherty-Biddison, L., Gwon, H., Regenberg, A., Schoch-Spana, M., & Toner, E. (2017, August 24). Maryland Framework for the Allocation of Scarce Life-sustaining Medical Resources in a Catastrophic Public Health Emergency. http://www.bioethics.net/wp-content/uploads/2020/03/Daugherty-Maryland-framework-PH-emergency-2017.pdf?x76994.

Gwon, H., Haeri, M., Hoffmann, D. E., Khan, A., Kelmenson, A., Kraus, J. F., Onyegwara, C., Paradissis, C., Povar, G., Schwartz, J., Sheikh, F., & Tarzian, A. J. (2020). Maryland's Experience With the COVID-19 Surge: What Worked, What Didn't, What Next? American Journal of Bioethics, 20(7), 150–152. https://doi.org/10.1080/15265161.2020.1779404

Hoffmann, D. E., & Tarzian, A. (2020, March 31). Coronavirus: When there aren't enough ventilators, who will live, who will die?: COMMENTARY. baltimoresun.com. https://www.baltimoresun.com/opinion/op-ed/bs-ed-op-0331-coronavirus-ethics-ventilators-20200331-wvmek7oczzadxbfi564xmxd-p5u-story.html.

The Coronavirus Pandemic & Visitation Policies

As coronavirus outbreaks have spread across the country, hospitals and long-term care (LTC) facilities have implemented strict visitor policies limiting visitors who can see patients. While there are some good reasons for such policies, most notably limiting the opportunity for more individuals to be exposed to the coronavirus, there are also significant harms for patients, families, and staff, that result from such policies.

Since the early days of the pandemic in Maryland, hospital visitor policies have changed significantly. In the spring, when hospitals were overwhelmed by surges of patients, priority was given to limiting opportunities for more community spread and protecting the supply of personal protective equipment (PPE) for frontline staff. In general, hospital policies either entirely restricted visitors, outside of specific exemptions such as end-of-life visits, or allowed for a single visitor per patient (e.g., for laboring women). LTC facilities, faced with populations housed in close quarters who are at high risk of serious illness and death if they contract COVID-19, instituted similar practices.

Ethical Tradeoff

The creation of visitation policies in the midst of the coronavirus pandemic required ethical tradeoffs. Strict visitor policies prevented community spread, benefitting both the individual visitor, staff, and the community at large. However, the resulting social isolation has had serious negative impacts (Karlawich 2020). The dependence many patients have on supportive family members in their medical care—particularly elderly patients— can make them vulnerable to the harms of isolation. Moreover, family-centered care has been understood as an important part of providing holistic care to the patient and vital in improving patient outcomes. Families play important roles in boosting patient morale, in ensuring that care plans fit the goals of the patient, and in acting as patient advocates. This can be especially true of patients in LTC facilities, where family members not only act as advocates, but also provide direct care to residents.

Some LTC facilities recognize that there is a meaningful difference between a visitor and a family member. The creation of the new designation "Essential Family Caregivers" acknowledges that family members provide time-intensive, essential care to residents who would otherwise require private duty care (Schlaudecker 2020). The designation also affirms that "maintaining connections between residents and their loved ones has safety, socio-emotional, and ethical components" (Schlaudecker 2020). Thus, banning visitors induces concentric circles of hardship for patients.

Technology Challenges

The social isolation of patients also has significant consequences for frontline staff, such as doctors and nurses, who have had to communicate via phone calls and videoconferencing with patients' family members. The development of "webside" manner for physicians and nurses should be a point of skill development for providing clear, effective, and empathetic telecommunication with families and patients (Azoulay 2020, Chua 2020). However, several challenges arise in transitioning to new modes of communication. Issues of privacy and functionality limit the use of commercially available video conferencing tools. The inability to block the call of origin in tools such as Whatsapp, Facetime and Skype have led to subsequent calls from families after staff have used their personal devices for emergent or end of life calls, distressing both parties (Life Lines 2020).

For patients and family members who are part of the Deaf or Hard of Hearing community, communication through masks and PPE can require unique adaptations to provide clear communication and education throughout clinical care. The National Association for the Deaf recommends a variety of assistive communication technologies such as speech to text apps that patients or providers can have available on smartphones to facilitate communication.

In cases where patients are unable to make their own medical decisions, the surrogate decision-maker must consent to plans of care without being physically present. Navigating difficult discussions around withdrawal of treatment, transition to end-of-life care goals, or patient death via phone call or videoconference has the potential to be traumatizing to all parties involved.

One small technology change that can make things easier for providers is for institutions to develop protocols for creating and using phone directories of patient and family member contacts. Such directories would facilitate finding the correct phone number for a patient's surrogate decision maker. Related to that suggestion, institutions could also provide technology devices and software to help providers access such directories across institution tablets or devices (Life Lines 2020). These measures can offset the burden for providers finding the information they need. This, in term, can eliminate or mitigate at least one kind of stress when difficult conversations with family need to be had.

Relaxing Visitor Policies

As the summer wound to a close and COVID-19 hospitalization in Maryland slowed, hospitals re-evaluated their strict visitation policies. (LTC facilities must abide by strict regulations before they can allow face-to-face visitation.) In some areas, relaxed visitation policies may be allowed if COVID case counts are low. However, relaxed visitation requires ample supplies of PPE for visitors and staff to ensure that the PPE is properly donned and doffed, and access to testing when there is a known facility exposure.

The CDC's current recommendations on relaxing visitor restrictions includes various safeguards as more visitors are allowed in to see patients, including screening of visitors for symptoms, making sure that proper time and equipment is allocated to educate families and visitors on PPE, informing visitors of exposure risks, and preventing exposure during aerosolizing procedures, etc. For more information on CDC's visitor policy see the references below (Centers for Disease Control and Prevention).

Christen Paradissis, RN, MBE
University of Utah
MHECN Program Coordinator

References

Azoulay, E. & Kentish-Barnes, N. (2020). A 5-point strategy for improved connection with relatives of critically ill patients with COVID-19. The Lancet. Respiratory medicine, 8(6), e52. https://doi.org/10.1016/S2213-2600(20)30223.

Centers for Disease Control and Prevention. Management of Visitors to Healthcare Facilities in the Context of COVID-19: Non-US Healthcare Settings. Centers for Disease Control and Prevention. https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/hcf-visitors.html.

Chua, I. S., Jackson, V. & Kamdar, M. (2020). Webside Manner during the COVID-19 Pandemic: Maintaining Human Connection during Virtual Visits. Journal of palliative medicine, 10.1089/jpm.2020.0298. Advance online publication. https://doi.org/10.1089/jpm.2020.0298.

Karlawish, J., Grabowski, D. C. & Hoffman, A. (2020, July 13). Opinion | Continued bans on nursing home visitors are unhealthy and unethical. https://www.washingtonpost.com/opinions/2020/07/13/residents-good-nursing-homes-should-consider-re-allowing-visitors/.

Life Lines Team (2020). Restricted family visiting in intensive care during COVID-19. Intensive & critical care nursing, 60, 102896. https://doi.org/10.1016/j.iccn.2020.102896.

Schlaudecker J. D. (2020). Essential Family Caregivers in Long-Term Care During the COVID-19 Pandemic. Journal of the American Medical Directors Association, 21(7), 983. https://doi.org/10.1016/j.jamda.2020.05.027.

Program Coordinator Transition

Anita Tarzian begins new job at the VHA

In June, Anita Tarzian transitioned from her roles as MHECN's Program Coordinator, an independent ethics and research consultant, and as Associate Professor at the University of Maryland School of Nursing, to serve as the Deputy Executive Director of the Veterans Health Affairs (VHA) National Center for Ethics in Health Care (NCEHC). The NCEHC serves as VHA's authoritative resource for addressing the complex ethical issues that arise in patient care, health care management, and research across VA facilities nationwide. The Center provides ethics analysis, information, education, advice, and support to VA facilties across the country, and leads nationwide quality improvement projects. The Deputy Executive Director is responsible for ensuring high quality program development and management and implementing organizational change to respond to VA and VHA initiatives. Despite her full-time position at the VHA, Dr. Tarzian will continue to work with MHECN as its Program Advisor.

Christen Paradissis joins MHECN as Program Coordinator

Christen Paradissis will be stepping into the Program Coordinator role and working with Diane Hoffmann, MHECN Director and Dr. Tarzian in her role as Program Advisor. Christen is a registered nurse, and graduated from University of Maryland's School of Nursing with her Bachelors in Nursing in 2016. She worked at the University of Maryland Medical Center in in-patient thoracic surgery for 3 years. She received her Masters in Bioethics from the Berman Institute of Bioethics at John's Hopkins University in 2019, and is currently studying philosophy at the University of Utah.

CASE PRESENTATION

One of the regular features of this Newsletter is the presentation of a case considered by an ethics committee and an analysis of the ethical issues involved. Readers are both encouraged to comment on the case or analysis and to submit other cases that their ethics committee has dealth with. In all cases, identifying information about patients and others in the case should only be provided with the permission of the patient. Unless otherwise indicated, our policy is not to identify the submitter or institution. We may also change facts to protect confidentiality. Cases and comments should be sent to MHECN@law.umaryland.edu.

CASE STUDY FROM A MARYLAND HOSPITAL

Ms. C is a 65 year old woman transferred to the hospital from a nursing home. Ms. C does not have decision-making capacity and has no written advance directive. She receives nutrition through a feeding tube and is completely dependent on others for her activities of daily living. She does not appear to communicate meaningfully with others but if agitated she can be comforted. She has a guardian who does not have authority to make decisions regarding code status. The MOLST form indicates she is full code.

Ms. C. has a history of severe dementia, cerebral palsy with developmental delay, recurrent upper gastrointestinal (UGI) bleeding from esophageal ulceration and esophagitis, anemia, recurrent urinary tract infection with multiple drug resistant organisms, congestive heart failure, deep vein thrombosis (DVT) with an inferior vena cava (IVC) filter, and multiple admissions to the hospital over the past year primarily for UGI bleeding and infection. She was admitted to the hospital in April 2020 during the COVID-19 surge and was found to have COVID-19 pneumonia. She was initially treated in the ICU with high-flow oxygen through a nasal cannula and hydroxychloroquine. Her oxygenation improved and she was transferred to the medical ward on 4 liters oxygen per nasal cannula.

Two days later she developed worsening respiratory distress and hypoxemia. An ethics consult was requested regarding the ethical appropriateness of withholding CPR and mechanical ventilation as medically ineffective treatments.

NOTE: Post case: the hospital withheld CPR attempts and mechanical ventilation and the patient survived to discharge.

Commentary from a Geriatrician and Former Ethics Committee Chair

Ms. C represents a class of patients well known to clinicians and hospital ethics committees: someone who is profoundly ill, even possibly terminally ill, about whom we know little in the way of values or life history, and for whom the current goals of care (in this instance, per her MOLST) seem not to comport with her clinical history. We are asked to "do everything" in the context of profound chronic and progressive illness. Such cases cause consternation and moral distress for the treating clinicians and are often challenging for the ethics committee or consultant. The central ethical question for this case "How aggressively to treat Ms. C's apparentlydeteriorating respiratory status?" depends on a variety of factual and ethical considerations.

The array of options available to the clinicians include: intubation and resuscitation in response to pulmonary or cardiopulmonary collapse with treatment until subsequent cardiac arrest or neurologic death, a trial of intubation with prespecified criteria for withdrawing support, with or without the addition of cardiac resuscitation, aggressive management but no intubation or resuscitation, or comfort care only. What should be considered in making a choice among those options?

At the outset, we learn that Ms. C is severely demented, requiring tube feedings, and that she is minimally interactive, but can be calmed when agitated. What we do not know is how much of a decline this represents from her prior state of cerebral palsy with developmental delay, or over what period of time this decline has occurred. We do not know, in this instance, whether Ms. C was happy and beloved, despite an already severely diminished capacity, or whether she has deteriorated significantly from a status she had previously accepted. The absence of an advance directive is distressing, but the guardian, while not authorized to make a DNR decision, may be able to fill in important blanks regarding Ms. C's life --what made her happy or unhappy and/or what her family situation was like, prior to the present moment. We might also learn about the religious commitments to which her family adhered. At the very least, such knowledge might help, for instance, in deciding about the point in Ms. C's life at which comfort care or hospice might indeed be aligned with Ms. C's best interests, and in informing a judge who might have to weigh in on such decisions. Whatever is decided regarding Ms. C's immediate care, an effort to learn as much as we can about her as a person, not just as a very sick patient, is ethically obligatory.

The patient is at this moment critically ill, however. Trying to sort out whether comfort care is an option may require more time than is available. So, what of the other treatment alternatives? Should resuscitation and intubation in this case be foregone completely, or offered as "trials", or offered without caveat? Do these interventions meet the criteria to be considered medically ineffective, following the guidelines of the Maryland Health Care Decisions Act (HCDA), i.e. will they fail to benefit the patient's health status, in the opinion of two physicians? [1]

While there are instances where a medical intervention is arguably truly ineffective (ventilator therapy failing to raise a patient's oxygen level, for instance, or CPR in an adult patient with advanced cerebral herniation), I would argue that Mrs. C is not such a case. Her status is fragile, granted. Ms. C, having dementia and dependent on a feeding tube, has perhaps a 50% likelihood of living 6 months.[2] In fact, given her multiple upper GI bleeds and repeated urinary tract infections with drug resistant organisms, her life expectancy may be even shorter. Furthermore, frail elderly individuals with COVID and heart disease who deteriorate to the point of requiring intubation have a relatively poor chance of survival.[3] In neither case, however, is there zero or near zero likelihood that the intervention will succeed; the odds are just very low. The ethical justification for withholding intubation and resuscitation therefore does not rest on these probabilities alone. The criteria for medical ineffectiveness are not met, depending on how one defines a "reasonable degree of medical certainty."

In this case, what other facts and values might affect the decision? A major consideration is that there is the very real risk of transmission of SARS-Cov-2 to health care practitioners, especially in the context of emergent intubation and resuscitation.[4] While such considerations do not fall under the rubric of medical ineffectiveness per se, it is legitimate to ask for which patients such interventions justify the risk. This patient has a substantial cardiopulmonary risk of poor outcomes due to her history of congestive heart failure. Furthermore, she is at overall risk of vascular complications from COVID due to her history of deep vein thrombosis, and contraindications to anticoagulation (a key treatment for COVID), and due to her history of gastrointestinal bleeding. Given all these reasons to believe that the outcome would be poor, the risk of COVID exposure for clinicians, which would be associated with intubation and resuscitation in this patient, seems disproportionate.

Another issue, beyond the scope of this case discussion, but clearly the "horse on the table" is the allocation of resources. If staffing, ICU beds, or ventilators are in short supply, how would that affect the decision-making regarding Ms. C? Judgments about ineffectiveness are challenging because awareness of context is almost impossible to avoid. Similarly, inherent bias (in this case, perhaps, against someone with a long term disability) may also play a role in clinicians' attitudes about access to health care interventions.[5] In making decisions about intubation and resuscitation, the ethics consultant(s) and the clinical staff will have to directly address whether these other issues are playing a role. Judgments that a course of treatment is medically ineffective should not provide "cover" for these other issues.

In this instance, we are assuming there is no pressing shortage of resources. The medical assessment rests on Ms. C's overall frailty, cardiac and hematologic risk factors, resulting in a very low probability of survival, and those facts combined with the risk to the practitioners of intubation and resuscitation justify withholding those modalities. Taken together, we arrive at the ethical decision, in the immediate context, of writing orders not to resuscitate or intubate (DNR/DNI), but to maintain all other interventions to address

Ms. C's problems. This decision should be implemented immediately, since the risk of intervention on the one hand, and the poor prognosis on the other are unlikely to change in the near term. Since the court will likely have to weigh in on the ethics consultants' recommendation (because the decision is not based on medical ineffectiveness alone), an emergency appeal to the courts may be necessary to implement the order.[6]

In fact, for Ms. C, the decision not to intubate may have been felicitous. What we know about treatment for COVID-19 is a moving target. Where ventilation early in hypoxia was normative in March 2020, the current standard of care is to use High Flow Nasal Oxygen, or Non-Invasive Ventilation, and proning instead. In fact, the survival of the elderly, who generally face increased complications when ventilator dependent, may improve as the standard of care moves away from early intubation. Ms. C may actually have survived in part because she was not deemed a candidate for intubation! That said, the decision to implement DNR/DNI orders was appropriate given the risk/benefit equation confronting the ethics consultant(s) at the time. The retrospective knowledge that Ms. C survived does not invalidate that recommendation.

The case provides further support for the position that medical intervention is not a binary variable—either full speed ahead, or comfort care only. As described at the beginning of this essay, there is a continuum of aggressiveness of care available to clinicians and ethics consultants, and all should be taken into account as decisions are made. The decision not to resuscitate or intubate should never be taken to mean "do nothing."

And finally, Ms. C's survival from this encounter offers the opportunity to circle back and do what can be done to ascertain the appropriate criteria for medical decision making going forward. The MOLST form should be conscientiously reevaluated, not because resuscitation and intubation were foregone on this hospitalization—that choice was specific to this disease context – but because Ms. C is owed this discussion just as much as any other patient in her situation. Such steps not only respect Ms. C, but help to address the moral distress clinicians experience making decisions about such patients, by providing a more robust basis for the choices to be made in the future.

Gail J. Povar MD, MPH
Former George Washington Hospital Ethics Committee Chair
Potomac, MD

---

[1] Annotated Code of Maryland, Health General Article, Subtitle 6: Health Care Decisions Act, as amended 2018. "Medically ineffective" treatment is defined in the Code as treatment that, "to a reasonable degree of medical certainty, will not prevent or reduce the deterioration of the health of an individual or prevent the impending death of an individual."

[2] Ijaopo EO, Ijaopo RO. Tube Feeding in Individuals with Advanced Dementia: A Review of Burdens and Perceived Benefits. Journal of Aging Research.2019: 10.1155/2019/7272067.

[3] Cummings MJ, Baldwin MR, Abrams D et al. Epidemiology, Clinical Course and Outcomes of Critically Ill Adults with COVID-19 in New York City: A Prospective Cohort Study. Lancet 395:10239. June 6, 2020.

[4] Interim Guidance for Healthcare Providers During the COVID 19 Outbreak: CPR and Emergency Cardiovascular Care. American Heart Association.

[5] Amundson, Ron. (2005). Disability, ideology, and quality of life: A bias in biomedical ethics. 10.1017/CBO9780511614590.005.

[6] https://www.marylandattorneygeneral.gov/Pages/HealthPolicy/eolcare.aspx#3b. Letter to Anita Tarzian regarding Medically Ineffective Treatment and Guardianship, 2003.

COMMENTARY FROM A FORMER HOSPITAL SOCIAL WORKER

The case described is not unusual. Questions about limiting the escalation of more aggressive interventions emerge frequently in ethics consultation. What is different is that this request emerged in the setting of a pandemic with attendant fears that the communities' needs will exceed available resources requiring some type of crisis triage protocol to allocate services and treatments. People who have historically and systemically been disadvantaged might suffer disproportionately when competing for resources. Their advocates step up to make the arguments for equity and justice in those allocations. Below is an example of how this case may be documented using Jonsen et. al's "4-Box" method (Jonsen et al., 2002).

Request for consultation: Ms. C is a 65-year-old woman transferred to the hospital from a nursing home. Ms. C does not have decision-making capacity and has no written advance directive. She has a guardian who does not have authority to make independent decisions about code status. The MOLST form indicates the patient is "full code." An ethics consult is requested to opine on the ethical appropriateness of withholding cardiopulmonary resuscitation and mechanical ventilation based upon its potential ineffectiveness in this setting.

Medical Indications –The Principles of Beneficence and Nonmaleficence
Ms. C. has a history of severe dementia, cerebral palsy with developmental delay, recurrent upper gastrointestinal (UGI) bleeding from esophageal ulceration and esophagitis, anemia, recurrent urinary tract infection with multiple drug resistant organisms, congestive heart failure, deep vein thrombosis (DVT) with an inferior vena cava (IVC) filter, and multiple admissions to the hospital over the past year primarily for UGI bleeding and infection. She was admitted to the hospital in April 2020 during the COVID-19 surge and was found to have COVID-19 pneumonia. She was initially treated in the ICU with high-flow oxygen via nasal cannula and hydroxychloroquine. Her oxygenation improved and she was transferred to the medical ward on 4 liters of oxygen by nasal cannula. Two days later she developed worsening respiratory distress and hypoxemia. Physicians believe that due to these multiple co-morbidities, mechanical ventilation would not benefit her, and that at the point when Ms. C's heart or breathing stop, CPR would not achieve its goal. They are requesting that these interventions be withheld.

Patient Preferences – The Principle of Respect for Autonomy
All too often, individuals with disabilities are victims of others' false assumptions about their poor quality of life and related projections. Given Ms. C's history of cerebral palsy and developmental delay, it would not be surprising if this happened over the course of her life. Most unfortunately, her preferences about how much discomfort she would be willing to endure to prolong her life are unknown. The history does not indicate whether she ever had capacity to express a preference. "Cerebral Palsy with developmental delay" covers a wide spectrum of ability, as does the diagnosis of "dementia." Social and family histories that might inform our understanding of her preferences are not available. Efforts should be made to find more information about her life experiences, personality, and how her history might inform her current plan of care.

Quality of Life – The Principles of Beneficence, Nonmaleficence in Gauging Best Interest
The patient is dependent in all activities of daily living and instrumental activities of daily living with those needs being met in a nursing home setting. She receives nutrition through a feeding tube.

These details might lead some to question whether prolonging her life would be of value to her. Her functional status has clearly deteriorated over the last year. The case summary states that she does not appear to meaningfully communicate with others but "if agitated she can be comforted." One needs to exercise caution in concluding that responding to another's attempts to soothe and comfort agitation is not a form of communication.

Since it's unknown what her wishes are, a best interest standard must be used in this case. Providing comfort is clearly of benefit, since she seems to experience agitation and others are able to soothe her agitation. This also indicates that she may suffer when experiencing agitation or discomfort. Thus, interventions that cause physical and emotional pain or discomfort should be justified by the benefits they provide.

Contextual Features – The Principles of Loyalty and Fiduciary Responsibility

No friends or family are involved in Ms. C's life, and no religious or cultural factors or financial matters that may affect the patient's treatment are known. Again, efforts to fill in the gaps in Ms. C's narrative are warranted. A guardian had previously been appointed by the Court. It is not clear why the guardian was not granted the ability to limit resuscitation or other life-prolonging interventions in the setting of a duly documented end-stage condition, vegetative state or terminal illness.

Governor Hogan's Emergency Declaration due to the COVID-19 pandemic is relevant, although crisis standards of care have not been invoked. Thus, critical care resources need not be rationed at this stage. However, the duty to steward resources requires that clinicians only provide medical care that is consistent with medical standards.

Recommendation: It is ethically defensible to withhold mechanical ventilation and cardiopulmonary resuscitation in this setting based on a determination that these interventions meet the definition of medically ineffective treatment according to Maryland's Health Care Decisions Act (HCDA). The guardian should notify the Court of this decision. Palliative care should be provided to maximize the patient's comfort.

If the patient is able to be discharged back to the nursing home, MOLST orders should reflect the new status. As a technical matter, whether the certification of the MOLST orders on page 1 of the MOLST form rests with the guardian or "Other legal authority in accordance with all provisions of the Health Care Decisions Act" will depend on whether the guardian is given authority by the Court to withhold CPR and mechanical ventilation. Absent this, the "Other legal authority …" section of the MOLST form can be checked on the new orders, and the guardian should be informed of this and should then notify the Court. Physician certifications of medically ineffective treatment should be documented in the medical record.

Discussion: The primary team with the support of the Ethics Consultation Service decided to limit what was possible, the intubation and mechanical ventilation of this critically ill person, in favor of a less invasive approach. Ironically, delaying ventilatory support in patients with COVID-19 turned out to be more life-preserving than previously thought. Thus, withholding ventilatory support may have actually helped this patient. Maryland's HCDA defines medically ineffective treatment as treatment that "will not prevent or reduce the deterioration of the health of an individual; or prevent the impending death of an individual," to a reasonable degree of medical certainty. If the guardian (in this case likely a public guardian) had been granted the right to make end of life decisions in the setting of end stage condition, he/she may have been able to consult with providers and weigh the benefits and burdens of proposed treatments. This was not the case. This is now a matter of law that focuses on two possible benefits of a proposed treatment: whether the treatment will prevent or reduce the deterioration of the patient's health or prevent the patient's impending death. The qualifying language makes it clear that the physician may make that decision based on a "reasonable degree of medical certainty." This gives the physicians certifying "medically ineffective treatment" some very limited discretion. In this case, it is possible that two physicians could find, to a reasonable degree of medical certainty, that providing Ms. C intubation and mechanical ventilation would not provide her with the specified benefits. It is also possible that two physicians would not agree that such treatment would be medically ineffective. In the latter case, the decision would be based on the patient's best interest and made by a judge.

Often these decision are fraught with "quality of life" assessments.

Disability rights advocates have

been alarmed by the vaguely disguised opinions that some lives must not be worth living. It takes on added gravitas as we anticipate choosing who may receive interventions and who may not if the Coronavirus surges overwhelm our resources. The paternalistic assumptions of some providers may well differ from the person who grew up like this woman with cerebral palsy. The case of Michael Hickson, a 46-year-old, African American man who had suffered a cardiac arrest that left him blind, quadriplegic and brain injured has become a recent example conflated with the stress of the pandemic (Shapiro 2020). Permanent guardianship was pending. The patient's wife recorded a provider as saying that the patient didn't have much of a quality of life. While Mrs. Hickson agreed that intubation and mechanical ventilation was not desirable, she and the provider disagreed on what else might be offered. The patient was placed in a palliative care unit where he died without family in attendance. The Office of Civil Rights at the Department of Health and Human Services is now investigating the case. We need to have the difficult and nuanced discussions that preserve as much autonomy as can be provided to all patients but that recognize that beneficence, non-maleficence, and justice have their role as well.

Joanne Kraus, LCSW-C
Johns Hopkins Bayview (Retired)

REFERENCES

Jonsen, Albert R., Siegler, Mark, Winslade, William J. (2002). Clinical Ethics: A Practical Approach to Ethical Decisions In Clinical Medicine (5th Ed.). New York: McGraw-Hill.

Shapiro, J. (July 31, 2020). "One Man's COVID-19 Death Raises The Worst Fears Of Manly People With Disabilities." NPR: Morning Edition.

COMMENTS FROM A LAWYER & BIOETHICIST

When a patient is unable to make health care decisions personally, two ethically and legally important questions arise: who makes these decisions, and what criteria guide them? Guardianship is a mechanism to answer these questions when preferred alternatives (the patient's advance directive or surrogate decision making) are unavailing.

When guardianship is in place, either the court-appointed guardian or the court itself makes health care decisions. The guardian makes most decisions by general delegation. However, a decision whether to withhold or withdraw a life-sustaining procedure is reserved for the court, unless the guardian has been explicitly empowered to make this type of decision (§13-708(c), Estates and Trusts Article, Maryland Code (ET).

The criteria by which a court decides whether a life-sustaining procedure is to be withheld or withdrawn parallel those usually applied in the clinical setting. The court is to consider evidence whether the patient "would, if competent, decide to withhold or withdraw [the] life-sustaining procedure under the circumstances" (ET §13-712(b)). This "substituted judgment" inquiry can be wide-ranging, examining what the patient said and believed and how the patient acted in the past (ET §13-711(d).

If the evidence falls short of being "clear and convincing" that the patient would refuse the procedure, then the court is to consider whether the evidence clearly and convincingly establishes that withholding or withdrawing the procedure would be in the best interest of the patient (ET §13-713(a)). This “best interest” judgment entails a detailed benefit/burden assessment of the procedure (ET §13-711(b)).

These criteria make sense only if a decision might potentially be made in either direction: to authorize the procedure, and thereby attempt to prevent the patient’s death; or to forgo it, given enough evidence in that direction. But what if the procedure has been determined by the patient’s attending physician and a second physician to be “medically ineffective” under the Maryland Health Care Decisions Act, because it cannot prevent the patient’s impending death even if it were performed? In that case, the Maryland Attorney General has advised, the decision not to offer the procedure is vested by law in the two physicians (79 Op. Att’y Gen. 218 (1994)). The weighing of evidence about substituted judgment or best interest is pointless when a procedure cannot, to a reasonable degree of medical certainty, accomplish the sustaining of life.

This summary of the law yields the following conclusions about the case of Ms. C: If CPR and mechanical ventilation have been certified as medically ineffective, a DNR/DNI order may be implemented without court permission. If, on the other hand, one or both procedures have not been certified as medically ineffective, the court would be the decision maker about their use. Given Ms. C’s history of severe dementia and developmental delay, it seems unlikely that a court would be able to find sufficient evidence that Ms. C, were she competent, would decline CPR and intubation. Hence, the determinative question for the court would be whether, considering benefits and burdens, CPR and intubation are contrary to Ms. C’s best interest.

Jack Schwartz
Former Maryland Assistant Attorney General
Member, Holy Cross Health and
MedStar Washington Hospital Center
Ethics Committees

SUPPORTING STAFF DURING THE COVID-19 PANDEMIC: FREDERICK HEALTH RESPONDS

In this article, Frederick Health Staff describe a number of ways the System has supported its staff during the pandemic. We hope that some of our readers will find these examples helpful as your institution looks for ways to support your staff during this challending time.

The last several months have brought many unexpected changes to Frederick hospital's workflow, building layout and staffing. Frederick Health has worked quickly to adapt to this ever-changing situation in an effort to support its staff and serve its community. Here are various examples of Frederick Health's response to the COVID-19 pandemic.

Incident Command

One of the first actions the hospital took was to form an incident command; a multi-disciplinary leadership team that was created to become the primary point of contact for questions, concerns and regular updates. During the last several months, life was changing around the hospital at record speed; offices were moved to accommodate the need for patient rooms, staff who were able were sent home to telework and a resource for up-to-the minute updates was immediately made available to all staff via email, phone and in-person staffing.

Video Update from our CEO

Frederick Health's CEO, Tom Kleinhanzl, provided video updates to all staff on a weekly basis while the incident command was operating daily. These updates provided encouragement, described changes that were to be expected and provided up-to-the minute statistics coming from the local health department.

Your Happy Place

Given the barrage of negative news, the Health System's administration implemented a weekly positive promotion of all things GOOD from Frederick Health, their community, and beyond. Happy news, stories, and photos were posted on the intranet on Frederick Health Connect.

Managing Stress – Staff Resources

Human Resources and Employee Wellness created a list of resources related to stress management, burnout and resiliency. These services are all available free of charge and posted on the hospital's intranet.

Employee Assistance Program

BHS, the hospital's Employee Assistance Program, provides the following staff support:

- BHS App – BHS provides assistance at staff's fingertips via their BHS App which can be found in the App store and Google Play store.

- By phone –Free, confidential, in-the-moment support available 24/7 to help with personal or work-related problems.

- By computer portal. BHSonline.com provides access to services, contains information about programs and trainings on a variety of well-being and skill building topics.

Service Excellence

Our Service Excellence department has truly made life in the hospital environment more bearable with their calming presence and seemingly never ending availability of resources. One imperative resource they provided was the ability to assist patients in electronically communicating with their loved ones outside of the building. Our Intensive Care Case Manager, Tena, shared that one of her most vivid memories of the last months was that of a young family being able to see their father through the iPad provided by Service Excellence. The father died, quite unexpectedly, during his admission but Tena shared that it brought her immense comfort knowing she'd been able to facilitate a 'last call' with those who mattered most to him.

MeetMe Chaplain Chats
MeetMe Chaplain Chats were created to connect members of the Frederick Health team and provide a vehicle for them to share experiences of the social and emotional dimensions of providing healthcare during the coronavirus crisis. These discussions are facilitated by a hospital chaplain, and the goal is to provide support, rather than problem solve or give advice.

Employee Relief Fund
Employees experiencing financial hardship due to the COVID-19 crisis have been able to request assistance through the Employee Relief Fund.

Staff and Provider Zen Space
A special area was set up in the rehab gym to provide staff with a respite space to relax and recharge. This space is open 24/7. Employees are required to keep their masks on, maintain physical distance, and clean items before and after use (wipes are provided) when utilizing this space. The Zen Space includes rocking chairs, a foot massager, a chair massager, and lounge chairs, water, hot tea, and chocolate candy, dim lights and relaxation music, stress kits, and a positive atmosphere of quotes and writing prompts that staff can take with them.

RISE – Resiliency In Stressful Events
A "Care for the Caregiver Peer Support Program" for peers in distress, the RISE Program was developed so that staff have another avenue available to deal with “second victim stress.” Peer responders are available 24/7. This confidential service is available free of charge.

Frederick County Trauma Recovery Network
Frederick Health has partnered with the Frederick County Trauma Recovery Network to offer free individual and group counseling for healthcare workers. This is confidential therapy, stress management, and trauma treatment support.

In conjunction with the hospital’s health coverage provider Optum, a toll-free 24/7 emotional support help line has been extended to the entire workforce, free of charge. It can also be shared with family and friends.

Allocation of Scarce Resources Policy
With direction from the State of Maryland, Frederick Health has developed a protocol in the event resources (such as equipment, supplies, and medications) become limited to the extent where the demand exceeds supplies. Their policy provides an ethical, clinical and legal framework to guide resource distribution, and ensures that decisions regarding which patients will receive the resource are not discriminatory in any way.

Treatment decisions are always based on individual evaluation of objective medical information, and triage decisions are made with an emphasis on the likelihood of both short- and long-term survival. The overarching goal is to preserve as many lives as possible. This step is included in this list of ways to support staff because uncertainty over how to manage decisions about scarce resource allocation for patients during this pandemic takes its toll on staff. Having a well-thought-out plan reduces staff anxiety that breeds from chronic uncertainty.

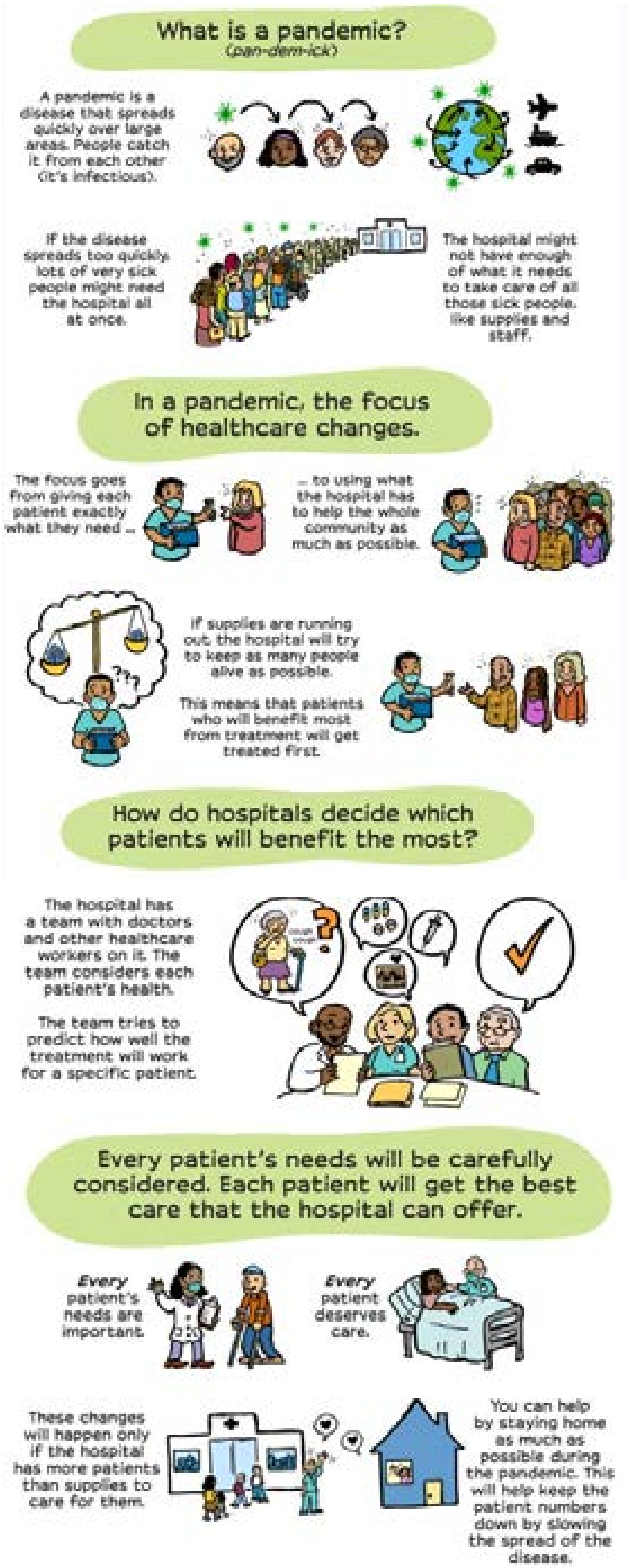
Tamara L. Kile, D.O.
Frederick Health Ethics Committee
Chair & Consultant

Michelle D. Ross, LMSWI
Frederick Health Ethics Consultant

Katie Slavin, DNP, MS, RN, CPHRM
Frederick Health Ethics Consultant

Explaining Pandemic Triage: When a Picture is Worth 3000 Words

The following is reprinted from The American Journal of Bioethics blog, where this comic can be downloaded [*http://www.bioethics.net/2020/06/explaining-pandemic-triage-when-a-picture-is-worth-3000-words/*](http://www.bioethics.net/2020/06/explaining-pandemic-triage-when-a-picture-is-worth-3000-words/)



Ethics and its implications for healthcare delivery under constraints of scarcity are not simple concepts, even for those working within the healthcare system. It's time for ethicists to make a concerted effort to communicate these concepts to a broader public audience. Pandemic triage protocols call for transparency, because it leads to understanding and in this way increases the trust patients and families have in the healthcare system This commitment to transparency requires an explanation of how hospital care might differ during a pandemic. Understanding that the hospital has a plan may reduce fear that allocation decisions are made unfairly. Toward that end, six clinical ethicists from different disciplines and areas of the country, along with an illustrator with a master's degree in Health Communication, worked together to create an illustrated handout to explain basic concepts of public health ethics relevant in a pandemic.

More than half of American adults – approximately 90 million people – have less than proficient levels of health literacy. Health literacy refers to a patient's ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions. This ability is further reduced during times of stress and illness, such as when someone seeks care for possible COVID-19. The use of illustrations for health instructions has been shown to increase patient engagement with and recollection of the information presented (Houts et al., 2006). Informational comics have been used to improve science scores among non-science major college students, and also to boost the comprehension of emergency department discharge instructions. For these reasons, we decided a comic would make a good vehicle for quickly informing patients and family members about the concept of scarce resource allocation during a pandemic.

The initial list of the ethically-relevant concepts we hoped to include in the comic was pages long, ranging from obligations hospitals owe physicians, to rights of disabled patients, to reasons for visitor restrictions. We decided to start with the foundational concept of triage. Clearly and accurately explaining that concept was in some ways more complex than penning a 3000 word journal article. Once the text and graphics came together, we received multiple rounds of invaluable feedback from representatives of the public, a patient and family advisory board from one of our institutions, and persons with expertise in disability rights advocacy.

We encourage everyone reading this to freely share this comic with patients and their family members during the COVID-19 pandemic. Uncertainty regarding when and how resources are allocated may cause anxiety for patients and families. Reducing that anxiety improves individual well-being and can help build trust in the health care system, which is so essential in times like these. In addition to informing individuals at the hospital, the comic could be used within communities as a springboard for discussion. The pandemic is placing us all on new footing. We hope this resource will improve communication and understanding among hospital teams, patients, and community members. We welcome feedback about your experiences using the comic so we can improve future efforts.

by Leah R. Eisenberg,
Joan M. Henriksen,
Felicia G. Cohn,
Anita J. Tarzian,
Theresa S. Drought,
Heather Fitzgerald.

Art by Cathy Leamy

MHECN Bioethics Resources During COVID-19

In this section of the newsletter, we've replaced our regular calendar events with a list of online activities related to the COVID-19 pandemic as well as to racial justice in health care issues. The first two items include dates as they are upcoming synchronous events; the other listings are pre-recorded events that you can click on and listen to at your convenience or use for education sessions at your healthcare facility.

November 2nd, 5:00 - 6:00 p.m. - Professor Alta Charo, University of Wisconsin School of Law Challenges in Equitable Allocation of SARS CoV-2 Vaccine; Rothenberg Health Law & Policy Speaker Series. Register https://www.eventbrite.com/e/challenges-in-equitable-allocation-of-sars-cov-2-vaccine-tickets-125248691207?utm-medium=discovery&utm-campaign=social&utm-content=attendeeshare&-aff=escb&utm-source=cp&utm-term=listing

November 10, 9:00 a.m. - 12:00 p.m. - 7th annual interprofessional ethics and religion forum. This year's topic is vaccines co-sponosored by MHECN.
Link to registration site: https://www.nursing.umaryland.edu/academics/pe/events/interprofessional-forum-on-ethics-and-religion-in-health-care/

<u>Recorded webinars:</u>

What Principles Should Guide our Lock-Down Strategies for COVID-19, Now and in the Future?

- Presentation
- Hosted by UNC Program for Public Discourse and the UNC Center for Bioethics

Black Bioethics: Racism, Police Brutality, and What it Means for Black Health

- Presentation
- Hosted by The American Journal of Bioethics

Pandemic Means the Whole World: COVID-19 and Global Bioethics

- Presentation
- Hosted by Kennedy Institute of Ethics

Medical Ethics During COVID-19

- Presentation
- Hosted by Holy Name Medical Center

COVID-19: PRIORITIES IN HEALTH Pop-Up Conference on Priority Setting

- Livestream Recording
- Hosted by Bergen Centre for Ethics and Priority Setting (BCEPS) at the University of Bergen

Ethics in the Research Response to COVID-19

- Presentation
- Hosted by Nuffield Council on Bioethics

Under the Blacklight: The Intersectional Vulnerabilities that COVID Lays Bare

- Part 1 and Part 2
- Hosted by The African American Policy Forum

The Vaccine: When, Where, and for Whom?

- Presentation
- Hosted by The National Academies

Worst Case Scenarios: COVID-19, Ethics, and Triage

- Presentation
- Hosted by The Exchange and the Berman Institute of Bioethics

The Race for a Vaccine: Balancing the Promise, the Peril, and the Process

- Presentation
- Hosted by The Science and Entertainment Exchange

Rationing Medical Resources in a Pandemic

- Presentation
- Hosted by Johns Hopkins Berman Institute of Bioethics

Ethical Dilemmas in Mask and Equipment Shortages: Health Care During the COVID-19 Pandemic

- Presentation
  The host is the Petrie-Flom Center and Lecturer on Law, Harvard Law School. Panelists are:

- Stephen P. Wood, Fellow in Bioethics, Center for Bioethics, Harvard Medical School
- Christine Mitchell, Executive Director, Center for Bioethics, Harvard Medical School
- Michael Mina, Assistant Professor, Center for Communicable Disease Dynamics, Department of Epidemiology, Harvard T. H. Chan School of Public Health

- **Moderator:** Carmel Shachar, Executive Director, Petrie-Flom Center and Lecturer on Law, Harvard Law School

- Christine Mitchell, Ethical Dilemmas in Mask and Equipment Shortages: Health care during the COVID-19 pandemic
- Michael Mina, Ethical Dilemmas in Mask and Equipment Shortages: Health care during the COVID-19 pandemic

website: https://petrieflom.law.harvard.edu/events/details/ppe-guidelines-and-access-ethical-dilemmas-for-healthcare-during-the-covid-19-pandemic

Allocating Ventilators in a Pandemic

- Presentation
- Hosted by Harvard Medical School Center for Bioethics

Nursing's Role in Health Equity, Public Health Emergencies, and COVID-19 – Critical Issues for The Future of Nursing 2020-2030.

- Link Here
- Hosted by the National Academy of Medicine

Disability, COVID-19, and Triage: Exploring Resource Allocation and the Framing of Disability

- Presentation
- Hosted by the Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics at Harvard Law School and the Harvard Law School Library.

Empire State Bioethics Consortium

Inequality, Vulnerability, and Health Justice: Learning from the Pandemic: Link Here
The Importance of Palliative Care During The COVID-19 Pandemic: Link Here
Ethics Consultations During COVID-19: Link Here
What are the Obligations of the State during a Pandemic?: Link Here

Webinar Series

Ensuring Equity in the Time of COVID-19 Webinar Series
Hosted by Community Campus Partnerships for Health and the UNC Center for Health Equity Research

- Facts and Lessons Learned from Recent Disaster. Presentation
- Behind the Scenes and In the Shadows: Essential Employees in COVID-19. Presentation
- Justice for All: Pandemic Response in Incarcerated Populations Presentation
- Pandemic Protection for People who are Incarcerated Presentation
- Pandemic Call and Response: Black Queer & Trans Communities Presentation
- Birth Equity during COVID-19 Presentation
- Community Resilience & Healing during COVID-19 Presentation
- Fixing Broken Systems to Serve Communities of Color Presentation
- A Hidden Pandemic: Mental Health, Trauma, and Racial Healing Presentation

Re-opening the Nation, a Series of Hastings Conversations
Hosted by The Hastings Center

- What Values Should Guide Us? Presentation
- Privacy, Surveillance, and Digital Tools for Contact Tracing Presentation
- Should We Turn to Immunity Testing? Presentation

The Emergency Preparedness, Ethics and Equity Series
Hosted by UNC Gillings School of Global Public Health

- What Have We Learned From the Past? What is COVID-19 Teaching Us? Presentation
- Ethics Around the Table: Jim Thomas, "Ethical Pandemic Control" Presentation
- Pandemic Protection for People who are Incarcerated Presentation
- Rethinc. Labs — Data Privacy in the Era of COVID-19 — Contact Tracing: Privacy vs. Protection Presentation

Ethical Issues in the COVID Pandemic at Children's Hospitals
Hosted by Children's Mercy Bioethics Center, Children's Mercy Kansas City

- Session 1 Ethical Issues in the COVID Pandemic at Children's Hospitals; Panel Discussion Presentation
- Session 2 Ethical Issues in the COVID Pandemic at Children's Hospitals; Panel Discussion Presentation
- Session 3 Ethical Issues for Children in the COVID Pandemic: Racial Disparities and Their Impact on Disease Burden Presentation
- Session 4 Ethical Issues for Pediatric Nurses in the COVID Pandemic Presentation
- Session 5 Morale and Moral Psychology During the COVID Pandemic Presentation

Bioethics and Race Toolkit

http://www.bioethics.net/2020/06/toolkit-bioethics-and-race-blackbioethics/

RESOURCE LINKS:

https://www.childrensmercy.org/health-care-providers/bioethics-center/bioethics-webinars-and-podcasts/COVID-resources/

http://www.bioethics.net/

https://bioethics.msu.edu/recorded-webinars-off-campus

http://www.bioethics.net/2020/06/toolkit-bioethics-and-race-blackbioethics/

https://bioethics.unc.edu/webinar/

The Law & Health Care Program
Maryland Health Care Ethics
Committee Network
University of Maryland
Francis King Carey School of Law
500 W. Baltimore Street
Baltimore, MD 21201

The Maryland Healthcare Ethics Committee Network (MHECN) is a membership organization, established by the Law and Health Care Program at the University of Maryland Francis King Carey School of Law. The purpose of MHECN is to facilitate and enhance ethical reflection in all aspects of decision making in health care settings by supporting and providing informational and educational resources to ethics committees serving health care institutions in the state of Maryland. The Network attempts to achieve this goal by:

- Serving as a resource to ethics committees as they investigate ethical dilemmas within their institution and as they strive to assist their institution act consistently with its mission statement;
- Fostering communication and information sharing among Network members;
- Providing educational programs for ethics committee members, other healthcare providers, and members of the general public on ethical issues in health care; and
- Conducting research to improve the functioning of ethics committees and ultimately the care of patients in Maryland.

MHECN appreciates the support of its individual and institutional members. MHECN also welcomes support from affiliate members who provide additional financial support.

SUBSCRIPTION ORDER FORM
THE MID-ATLANTIC ETHICS COMMITTEE NEWSLETTER

NAME ______________________________

ORGANIZATION ______________________________

ADDRESS ______________________________

CITY, STATE, ZIP ______________________________

TELEPHONE/FAX NOS. ______________________________

E-MAIL ______________________________

No. of Subscriptions Requested:

________ Individual Subscriptions @ $35/yr.

________ Institutional (MHECN non-member) Subscriptions @ $90/yr. (up to 20 copies)

Please make checks payable to: ***The University of Maryland***

and mail to:
The University of Maryland School of Law
Law & Health Care Program - MHECN
500 West Baltimore Street
Baltimore, MD 21201

For information on MHECN membership rates, contact us at MHECN@law.umaryland.edu, or (410) 706-4457 or visit http://www.law.umaryland.edu/mhecn

All correspondence including articles, cases, events, letters should be sent to:

Diane E. Hoffmann
Editor
The Mid-Atlantic Ethics Committee Newsletter
University of Maryland Francis King Carey School of Law
L&HCP
500 W. Baltimore Street
Baltimore, MD 21201
E-mail: dhoffmann@law.umaryland.edu